Welfare, Health and Equality

Survey for 2012–2015



MINISTRY OF SOCIAL AFFAIRS
AND HEALTH, Finland

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

Senior civil servants

Socially Sustainable Finland 2020

Permanent Secretary
Päivi Sillanaukee

SUPPORT FOR MANAGEMENT

Director of Development
Klaus Halla

Advisory Staff assist with the implementation of the Permanent Secretary's responsibilities.

Director of International Affairs
Liisa Ollila

The International Affairs Unit coordinates work relating to international affairs. The International Affairs Unit is responsible for managing the processes of international organisations.

Director, Communications
Eeva Larjomaa

The Communications Unit is responsible for coordinating communications, interest group relations and publications of the Ministry of Social Affairs and Health and the ministry's administrative branch and for overseeing centralised communications, advocacy support and the development of these areas.

Director for Preparedness
Olli Haikala

The Preparedness Unit is responsible for coordinating preparedness issues.

OMBUDSMEN

The Ombudsman for Equality
Pirkko Mäkinen

is responsible for monitoring compliance with the Act on Equality between Women and Men.

The Ombudsman for Children
Maria Kaisa Aula

is responsible for promoting the interests and rights of children.

DIRECTORS-GENERAL

Aino-Inkeri Hansson

The Department for Promotion of Welfare and Health is concerned with: the promotion of social welfare and disease prevention; supporting social inclusion; safeguarding the welfare of children and young people; social assistance and housing allowance; dealing with drug and alcohol matters; environmental healthcare; and, questions concerning central government transfers to local government for social welfare and healthcare.

Kirsi Paasikoski

The Department for Social and Health Services is responsible for: the functioning of the service system and its tasks related to human resources; services for different population groups; family-policy benefits; pharmaceutical services; social welfare and healthcare information management; military injuries legislation; and legislation concerning the status and rights of patients.

Leo Suomaa

The Department for Occupational Safety and Health develops and prepares occupational safety and health legislation and national occupational safety and health policy, coordinates occupational safety and health research and oversees international occupational safety and health cooperation. The department is also responsible for the performance management of the occupational safety and health divisions of Regional State Administrative Agencies, which are in charge of monitoring compliance with occupational safety and health legislation in the workplace.

Outi Antila

The Insurance Department develops statutory insurance policies and prepares legislation relating to social insurance and private insurance. The Pharmaceuticals Pricing Board, which operates in association with the ministry, confirms the wholesale prices of medicines and decides on the medicinal products for which special reimbursement is available.

Raimo Ikonen

The Administration and Planning Department handles tasks relating to the financial and general administration of the ministry and its administrative branch, and their planning and performance management. It also prepares strategic reports. The department is also responsible for developing performance management and for overseeing the implementation of the Finnish government's equality policy.

POLITICAL LEADERSHIP

The Ministry of Social Affairs and Health has two ministers: the Minister of Social Affairs and Health and the Minister of Health and Social Services. In addition, the Minister of Culture and Sport is responsible for gender equality issues. The ministers oversee the policy process. They are assisted by state secretaries, special advisers and the ministry's entire organisation (see inside cover) under the leadership of the Permanent Secretary.

Minister of Social Affairs and Health
Paula Risikko

"There is always hope."

State Secretary
Pia Pohja

Minister of Health and Social Services
Maria Guzenina-Richardson

"There is a proverb: 'Even the tallest tower started from the ground'. Welfare is built from basic elements, which is why timeliness and respect for the individual are crucial for the service system to be functional and sustainable."

State Secretary
Sinikka Näätsaari

Minister of Gender Equality Affairs
Paavo Arhinmäki

"The aim of our gender equality policy is to break down the mechanisms that create and promote inequality between the sexes and the resulting unequal power structures and practices."

State Secretary
Jarmo Lindén

Welfare, Health and Equality

MINISTRY OF SOCIAL AFFAIRS
AND HEALTH, Finland

Foreword

The Ministry of Social Affairs and Health is responsible for overseeing Finland's social and health policy, gender equality policy and occupational safety and health policy. The ministry has its own role in the implementation of the Government Programme: preparing legislation, steering development and supervising the implementation of reforms. Various government agencies and public bodies support the ministry in this work.

Universal social protection and extensive welfare services are an essential element of the Finnish welfare state. Everyone living in Finland is entitled to social security and to social-welfare and healthcare services. The system covers a vast range of services, and almost all citizens make use of at least one benefit or service for which the Ministry of Social Affairs and Health is responsible in the course of a normal year.

The Ministry of Social Affairs and Health has extensive experience in planning and steering social security. Our strategic goal is to build a socially sustainable society by 2020. This requires a solid foundation of welfare, universal access to welfare and a living environment that promotes health and social security. A socially sustainable Finland will be fair to everyone and support everyone's health and functional capacity. It will also offer security and services to promote social inclusion and social relations.

Our challenges include population ageing, the development of the economy and employment, the sustainability of funding, and the access to social welfare and healthcare services at the regional level. The global economy, the European Union and international commitments have a strong influence on our national policies.

The significance of social and health policy as the foundation of social cohesion is widely recognised. Finland has been ranked at the top of several international welfare surveys. Finns themselves are also relatively content with their welfare state. Income security and social welfare and healthcare services need to develop in pace with general changes in society. We are currently reforming the organisation and operations of our entire social welfare and healthcare service system.

This publication is an overview of the scope of the work of the Finnish Ministry of Social Affairs and Health, our priorities and the way things are done in Finland.

"Never make cuts that will cost you more in the future."

Permanent Secretary,
Päivi Sillanaukee

THE FINNISH MODEL

Ministry of Social Affairs and Health at the helm of social policy

The development and economic growth of a welfare state requires a healthy workforce able to work, with as many people as possible participating in the labour market.

The goal of the Ministry of Social Affairs and Health is to ensure that everyone has an equal opportunity to lead a healthy and socially secure life. The ministry also works to build equality between men and women. It supports the population's health and functional capacity, promotes social equality and healthy living and working environments and ensures that everyone has access to adequate social welfare and healthcare services and a reasonable level of income at different stages of life.

The Ministry of Social Affairs and Health works at the core of social policy. The long-term strategies prepared by the ministry help to bolster the welfare of Finnish citizens and to steer Finland's social policy.

Strategic priorities as the foundation of the ministry's work

The mission of the Ministry of Social Affairs and Health is to build a socially sustainable society by 2020. Our strategic priorities are:

- a strong foundation for welfare,
- access to welfare for all, and
- a healthy and safe living environment.

Promoting gender equality is also an essential part of the work towards a socially sustainable Finland.

The core responsibilities of the Ministry of Social Affairs and Health include preparing and implementing legislation, strategic steering the administrative branch, cooperation with the EU and international partners, and operational and financial planning and monitoring. Practical work is divided into legislative development, various projects and programmes, and cooperation and advocacy relating to these. The ministry is responsible for a significant number of targets that affect the population's health and welfare and that are included in the Government Programme.

Cooperation across the administrative branch

The entire administrative branch of the Ministry of Social Affairs and Health shares the same goals. Each of the government agencies and public bodies operating in the ministry's administrative branch works towards these shared goals and contributes to projects relating to their respective areas of expertise according to the Government Programme. The ministry produces and concludes performance agreements with these units which specify targets for each four-year term. The implementation of the performance agreements is reviewed and the targets revised annually. There are a number of extensive programmes under way to promote the accessibility and quality of social welfare and healthcare services and to improve working life. The operations of the administrative branch of the Ministry of Social Affairs and Health have been streamlined in recent years to boost their productivity and cost-effectiveness. With higher productivity comes more efficient use of social resources in the coming years when Finland's population ages and its workforce dwindles.

The Ministry of Social Affairs and Health is responsible for:

- social and health policy,
- promotion of welfare and health,
- environmental healthcare,
- social welfare and healthcare services,
- social insurance (pensions, health insurance and unemployment benefits),
- development of private insurance,
- occupational safety and health,
- promotion of gender equality,
- coordination of research and development in the administrative branch, and
- international cooperation within its mandate.

Universal social security for all

The Finnish social security system is universal. That means that everyone has a universal and equal right to social security benefits and social welfare and healthcare services. All residents are entitled to pensions, sickness and parental allowances and unemployment benefits. All employees are also entitled to work-related benefits such as earnings-related pensions and occupational injury compensation.

The most important elements of Finland's social security system are risk prevention, social welfare and healthcare services, and income security. The population's welfare and earnings at different stages of life are guaranteed by a comprehensive system of services and social transfer payments, for which the Ministry of Social Affairs and Health is responsible. Local authorities are responsible for providing social welfare and healthcare services in their respective municipalities.

Private insurance companies administer a considerable portion of Finland's social insurance system even though the system is statutory. Social welfare is mainly funded by employers, the insured, the state and local authorities.

The Finnish model promotes social cohesion, fairness and equality. The system of transfer payments effectively levels out income inequalities; Finland has one of the lowest poverty rates in the EU. All children under school age are entitled to municipal day care, which gives mothers of small children an opportunity to participate actively in the labour market.

Health and welfare promotion aims to reduce risks and problems and to support the population's welfare. Citizens are encouraged to look after their own health and to cut down smoking and alcohol consumption. Environmental healthcare, primary healthcare, occupational safety and health, occupational healthcare and maternity and child-health clinics support problem and risk prevention. The objective is to prevent poverty and social exclusion proactively. Social and health policy plays an important role in this, both nationally (state) and locally (municipalities).

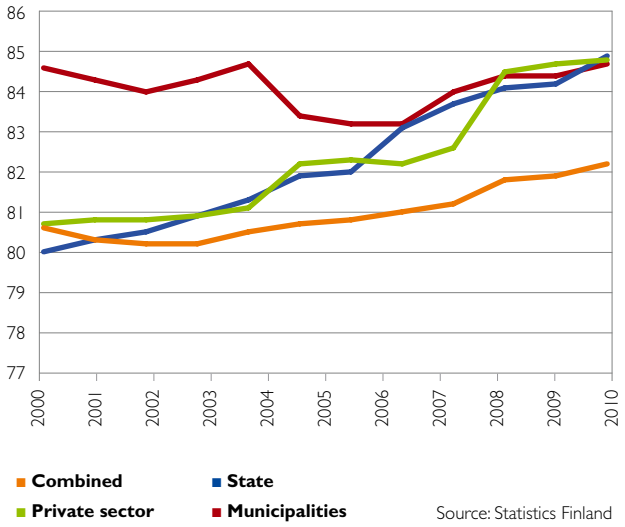
Equality between the sexes in the labour market and in decision-making

Equality between the sexes is an important part of the Nordic welfare model. It is also a precondition for a fair society. Equality between women and men is a fundamental right stated in the Constitution of Finland. The Finnish government is committed to promoting gender equality and has a specific Gender Equality Programme for this purpose. The overriding objective of the Gender Equality Programme 2012–2015 is to mainstream gender equality across all policy areas. Occupational safety and health authorities monitor compliance with the prohibition of discrimination according to both the Employment Contracts Act and the Non-Discrimination Act.

Finland, like other EU countries, is committed to mainstreaming of gender equality. Its objective is to develop administrative and operating practices that support equality as part of the core work of ministries and public authorities. Finnish citizens' attitudes towards and experiences of gender equality are surveyed by means of a Gender Equality Barometer every four years.

Women are still in a weaker position than men in the labour market. Getting women's and men's pay to the same level is difficult. Equal pay is nevertheless a precondition for maintaining the productivity of work. The Equal Pay Programme is aimed at reducing the difference between women's and men's pay to a maximum of 15 per cent by 2015.

Figure 1: Women's pay vs. men's pay, %



Source: Statistics Finland

The Finnish government is currently examining the effects of taxation and transfer payments on the economic equality between women and men. A large group of men are completely excluded from education and the labour market. Effects on both men and women need to be considered when making decisions about reducing poverty, inequality and social exclusion.

Reconciling work and family life is facilitated by giving more support to individuals returning to work after family leave. Development of the family-leave system takes into consideration that there are many different kinds of families. Equality between the sexes is also being introduced to the daily functioning of schools. Basic education will include equality planning, in addition to which equality will be incorporated into curricula and the basics of academic and vocational qualifications.

The percentage of women in political decision-making has increased both locally and nationally. The Act on Equality between Women and Men lays down that municipal executive boards and municipal committees must have an equal representation of women and men. The principle of equal representation is generally well observed in municipal decision-making bodies.

Most decision-making bodies are still chaired by a man. Men are also still overrepresented in the senior management of businesses: while women now account for almost 30 per cent of the members of the boards of directors of the largest listed companies, they are still a clear minority on the boards of directors of small and medium-sized enterprises and in the operational management of businesses.

Working with the EU and international organisations

International and EU-level policies have more and more influence on Finland's national policy. This trend is due to:

- globalisation and the global economy,
- climate change and environmental issues,
- sustainable development,
- ageing of the population,
- development of the information society,
- poverty and social exclusion,
- health-related threats, and
- challenges resulting from growing inequalities in health.

The Ministry of Social Affairs and Health engages in extensive international multipartite and bipartite co-operation with intergovernmental organisations, NGOs and interest groups. The European Union has legislative powers that are directly binding on the Member States. Finland has been a member of the Economic and Monetary Union (EMU) and the new Stability and Growth Pact from the beginning. The EMU has stabilised the economy and lowered Finland's high and unstable interest rate. Ageing of the population, restructuring of the labour market and pressure from globalisation require a strong economy to allow preparation for higher social spending in the future.

The EU wants to promote the free movement of people, goods, services and capital. The Finnish Ministry of Social Affairs and Health contributes to the development of the union's policy so that the functioning of national systems can be reconciled with the freedom of movement. Social and health policy and the internal market have increasing interaction with each other in ever more policy sectors.

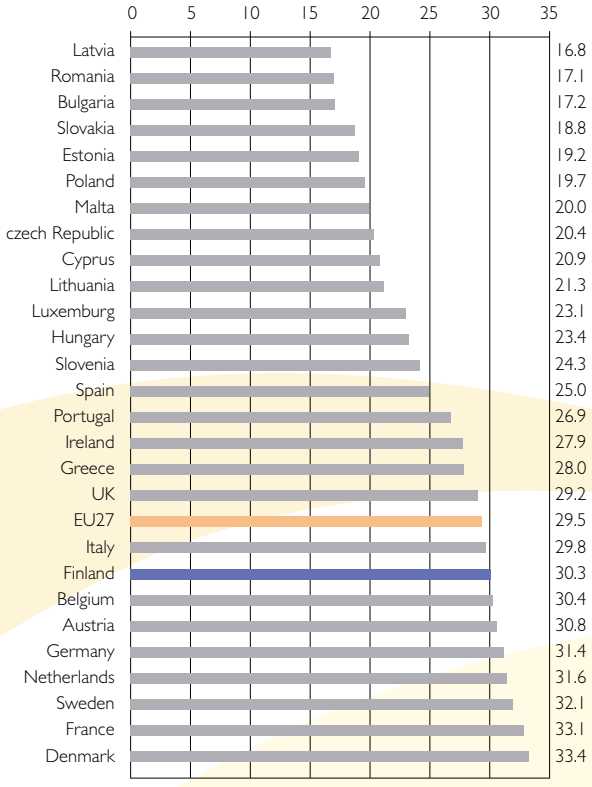
The EU's growth strategy is an important tool in economic, employment and social policy. The social dimension has been reinforced by the Treaty of Lisbon. The Treaty of Lisbon simplifies the union's legislative work. The harmonisation of social security is based on qualified majority decisions. The union's powers remain largely unchanged with regard to social policy, but more power is given to the union on health matters. The EU's health policy is based on the EU Health Strategy for 2008–2013, which was issued in 2007. Health policy overlaps with other policy sectors more and more often, and other policy sectors have ever increasing influence on health policy.

The Ministry of Social Affairs and Health plays an active role in the activities of the UN, the WHO, the ILO, the Council of Europe, the OECD, the Nordic Council of Ministers as well as other regional intergovernmental organisations. The Ministry of Social Affairs and Health is active in the governing bodies and committees of the UN and its specialised agencies. Finland is a signatory to most significant international human rights conventions. It also supports bipartite cooperation with other countries, especially in neighbouring areas.

Globally or regionally agreed political targets and legal commitments require national action. Finland advocates international policies that emphasise human rights, equality and non-discrimination as well as health and welfare promotion. The Ministry of Social Affairs and Health supports the visibility of Finnish social welfare and healthcare expertise, objectives and operating models and the sharing of best practices internationally.

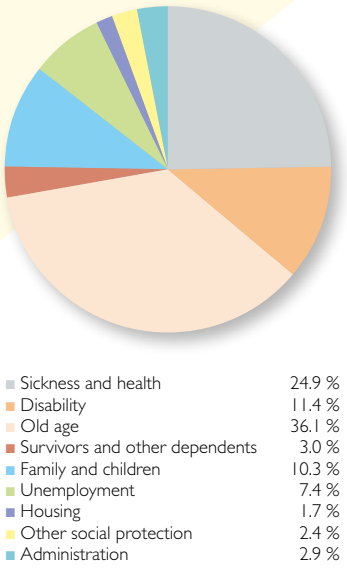
The progress of the UN's millennium goals that were set in 2000 will be reviewed in 2015, and new goals for international cooperation will be set. The Ministry of Social Affairs and Health will participate actively in the formulation of these new goals. International politics has become more complex with the addition of new countries (Brazil, India, South Africa, China).

Figure 2: GDP-equivalent social spending in EU countries in 2009



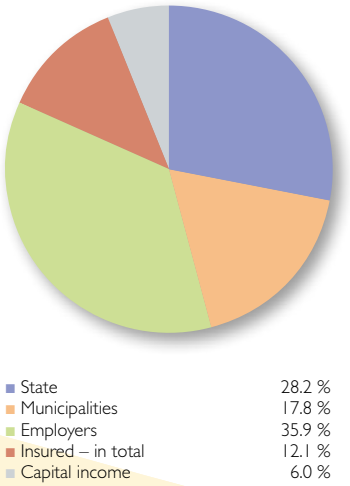
Source: Eurostat

Figure 3: Social spending by target group in 2011
(per cent of all spending, EUR 57 billion)



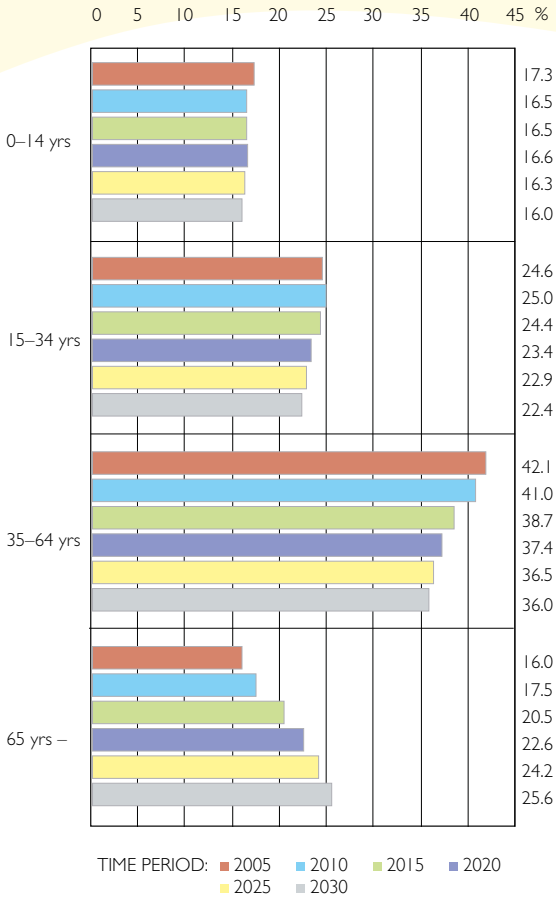
Source: MSAH

Figure 4: Total social-security funding in Finland in 2011



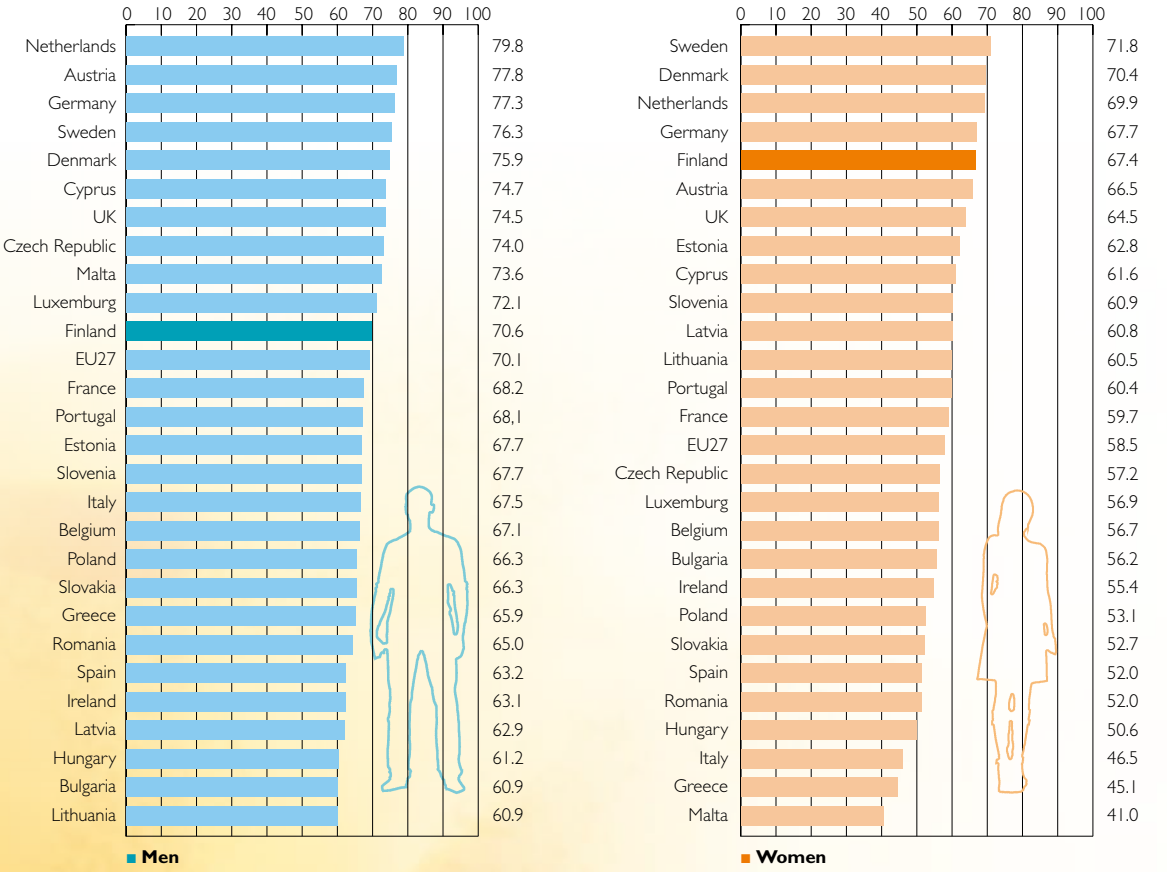
Source: MSAH

Figure 5: Population pyramid, distribution of different age groups, %



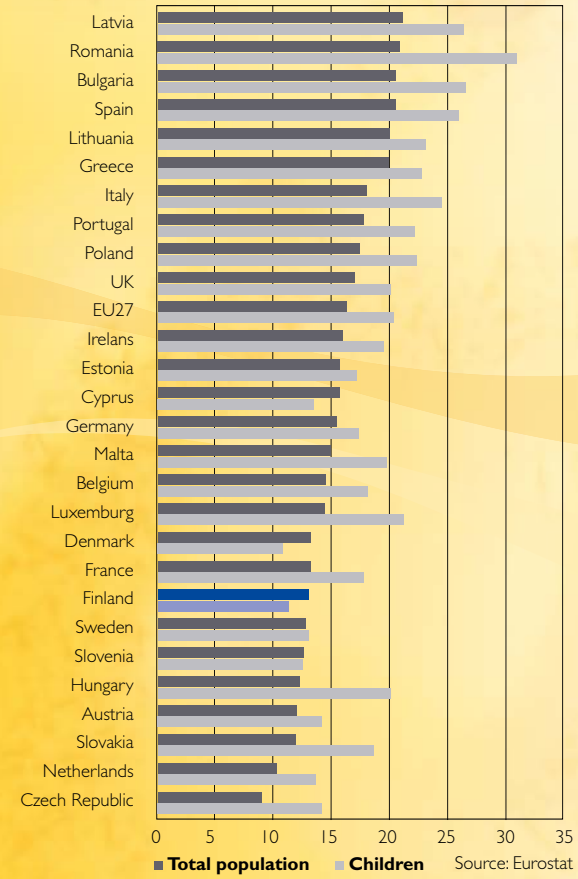
Source: Statistics Finland

Figure 6: Rate of employment in EU countries in 2011



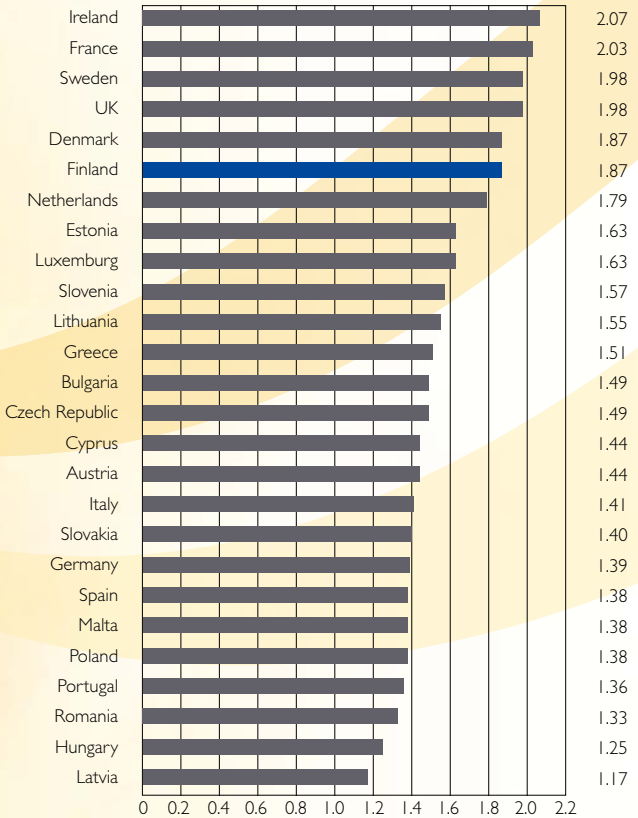
Source: Eurostat

Figure 7: Poverty rate in certain EU countries in 2010



Source: Eurostat

Figure 8: Total fertility rate in EU countries in 2010



The total fertility rate measures the number of children born. It has risen slightly in recent years and now exceeds the average across EU countries.

Source: Eurostat

WELFARE
YESTERDAY, TODAY AND TOMORROW

Health and functional capacity among Finns

Functional capacity and health have improved in all age groups in Finland. Life expectancy continues to rise. Women live, on average, seven years longer than men. In an international comparison, the gap is still wide.

Inequalities in health between socioeconomic groups and between the sexes, as well as regional inequalities, remain considerable. Health differences are the result of different living conditions and lifestyles such as alcohol consumption, smoking, diet and exercise. Educational background and earnings are strongly linked to health.

The Health 2015 programme outlines the targets for Finland's national health policy. The strategy focuses on health promotion. The programme crosses administrative boundaries, because issues beyond healthcare have a considerable impact on public health. The programme aims to reduce health inequalities between population groups and to improve health-promotion cooperation between administrative branches. The new Health Care Act, which entered into force in 2011, requires local authorities to monitor the health and welfare of their residents.

Health and functional capacity have improved among the working-age population. This allows for longer working careers. Efforts are made to increase the scope, quality and effectiveness of occupational healthcare. In the future, more emphasis in preventive occupational healthcare is needed on maintenance of work ability, evaluation of work-related health hazards and identification of reduced work ability. Efforts are made to improve the career opportunities of employees with partial work ability. More seamless cooperation is needed between occupational healthcare, other healthcare services and workplaces to allow treatment and rehabilitation to be initiated sufficiently early.

Revisions have been made to the Health Insurance Act and the Occupational Health Care Act to allocate more resources to early support of work ability. The work of occupational healthcare providers is governed by legislation which is implemented by the Good Occupational Health Practice guidelines as well as by extensive training for occupational healthcare personnel, specialised medical care and primary healthcare.

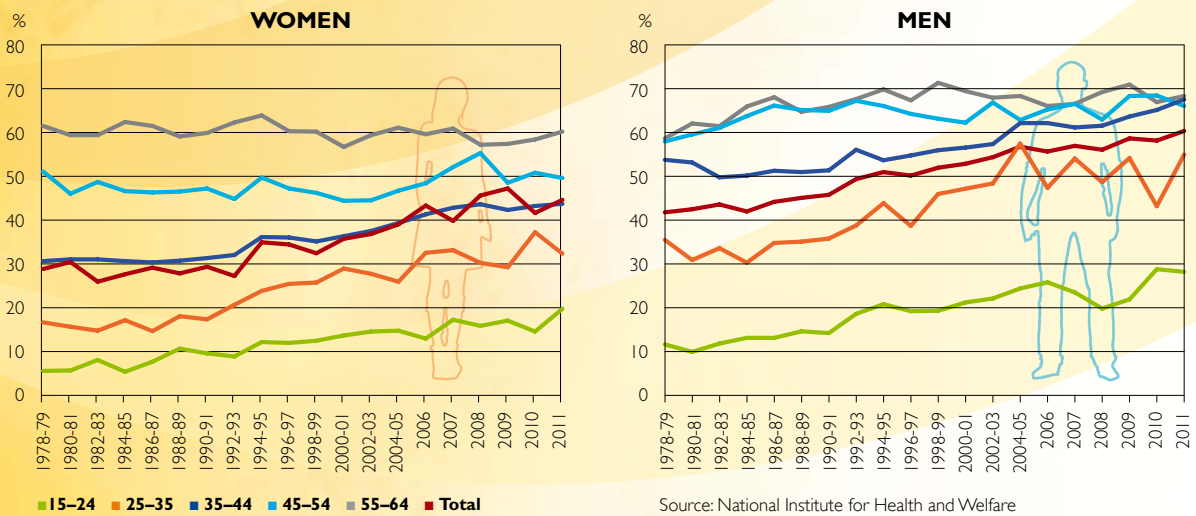
Efforts are made to improve the ability of people aged 75 and over to cope independently and to increase the ability of all older people to continue living in their own homes. The percentage of older people living in their own homes has remained unchanged. Functional capacity among older people has improved in recent years. Efforts are made to increase the opportunities for people with disabilities to participate in the labour market.

Multi-annual, extensive partnership programmes have been launched with the aim of reducing the damaging effects of substance abuse. Restrictions on importing alcohol for personal use from other EU Member States were removed and tax on alcohol lowered in 2004. The overall consumption of alcohol grew immediately. Problems related to alcohol, especially alcohol-related deaths, also increased. Tax on alcohol was increased three times in 2008 and 2009. Consumption is dropping slightly, but the associated problems are still rife.

Drug use and the associated problems have remained constant in Finland during the 2000s. The Drug Policy Programme focuses on providing adequate and appropriate treatment for drug users. Smoking among men has fallen steadily. The younger generations smoke a little less. Smoking among women remains almost unchanged. Differences in smoking between people with different educational backgrounds have remained high, and differences between women have increased.

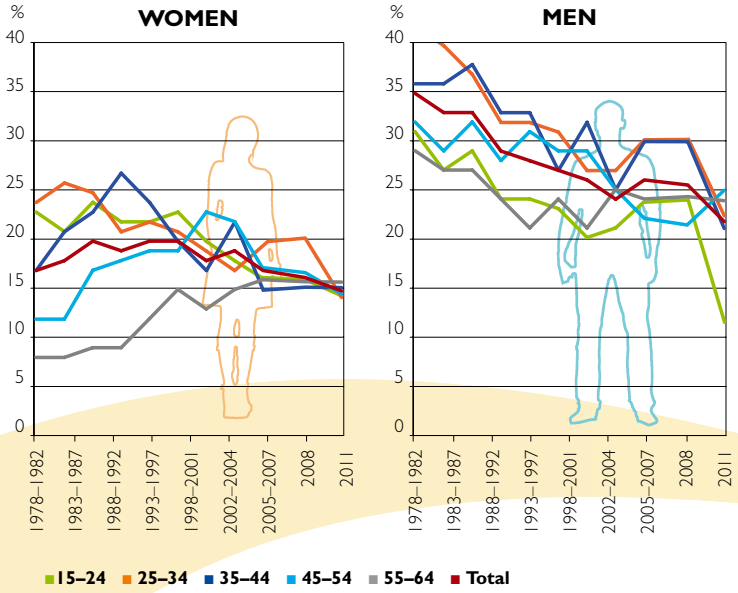
The percentage of smokers is low in the light of international statistics.

Figure 9: Obesity by age group between 1988 and 2011, %



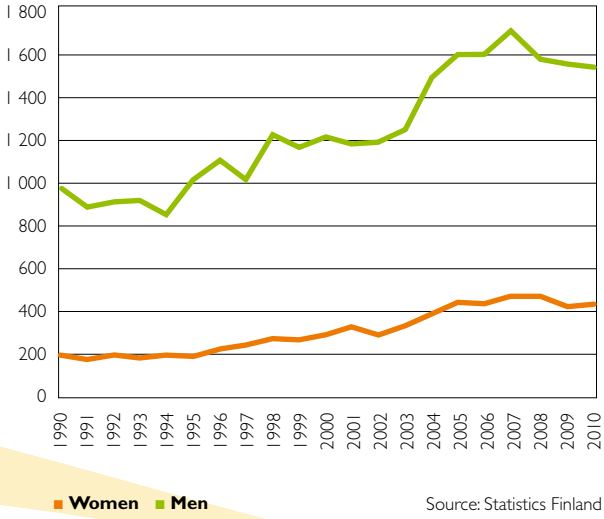
Source: National Institute for Health and Welfare

Figure 10:
Smoking by age group between 1978 and 2011, %



Source: National Institute for Health and Welfare

Figure 11:
Alcohol-related deaths between 1990 and 2010



Source: Statistics Finland

Mental health problems and especially depression have increased and are now the most common reason for people to retire on a disability pension. Suicide rates have been dropping for some time.

The goal is to close the gap of health inequalities between population groups and to reduce accidental or violent deaths among young men. The incidences of cardiovascular diseases and accidental deaths have already dropped. On the other hand, many illnesses relating to lifestyle and the environment, such as diabetes, asthma and substance-abuse problems, have become more common. Considerably fewer deaths than before are caused by coronary disease and cancer.

Children and young people are generally healthy, but obesity, for example, has increased. Obesity is becoming a public health issue. Despite the positive trends, more still needs to be done to reduce smoking and substance abuse. Even among children and young people, health differences are clearly linked to social and economic background.

A Government Resolution was issued in 2008 outlining a strategy to promote physical exercise and healthy eating habits among the population. The objective is to mainstream a physically active lifestyle and healthy diets across all population groups, but especially among the most vulnerable.

International cooperation in the prevention of infectious diseases has become increasingly important especially due to the threat of pandemics. Finland prepared for the swine flu (H1N1v) outbreak of 2009 by ordering enough vaccine for the whole population. The National Vaccination Programme is under continuous development in order to prevent the incidence of infectious diseases by means of new vaccines.

Towards better social inclusion and a lower poverty rate

One of the key initiatives of Prime Minister Jyrki Katainen's cabinet is to prevent poverty, inequality and social exclusion. The aim is to improve the level of income among the poorest segment of society. Efforts are made to reduce long-term and structural unemployment, long-term reliance on social assistance and poverty among families. The goal is for all administrative branches to come together to ensure access to local services. The plan is to increase the availability of different forms of social services, such as preventive healthcare for children and young people, as well as substance abuse, mental health and child protection services.

The Ministry of Social Affairs and Health strives to increase cooperation between different administrative branches in combating social exclusion. Homelessness needs to be reduced, and better drug rehabilitation services need to be developed. The public sector is supported in this task by a strong third sector, with Finland's Slot Machine Association providing invaluable funding.

Social inclusion and work are the best form of social security. Full-time employment is the best guarantee

against ending up on a low income. Social exclusion can be avoided if people have work and sufficient benefits, as well as efficient basic services, affordable housing and the opportunity to be included in their local community and to participate in society according to their own abilities.

The percentage of low-income and long-term low-income population has increased in recent years. The majority of people on a low income are unemployed or otherwise excluded from the labour market, part-time employees, low-income pensioners or students. Earnings among the bottom 10 per cent of the population have increased at a slower rate than in households on average. The rate of increase has been higher in the top income bracket.

Economic inequality breeds health inequalities. Life expectancy among men is no longer growing in the bottom-40-per-cent income bracket. The percentage of long-term unemployed has begun to rise after the recession that started in 2008. A high percentage of the long-term unemployed are aged over 50. Unemployment among young people has also increased, but young people tend to be unemployed for shorter periods of time.

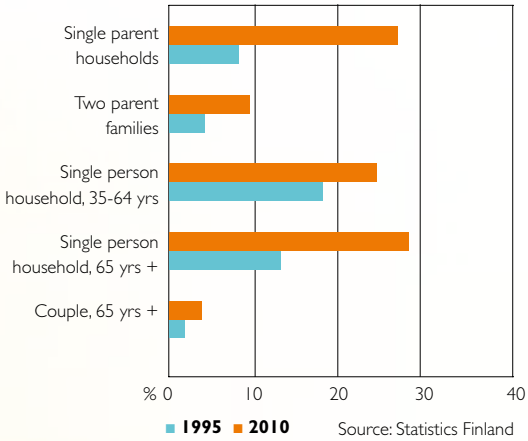
The adequacy of basic social security is evaluated every four years. The evaluation covers specific benefits such as the benefits and social assistance available from the Social Insurance Institution of Finland (Kela) along with basic income and factors affecting this. Incentive problems are being reduced by eliminating the effect of a spouse's income on labour-market support.

Efforts are made to increase employment among young people. The most important tool is the so-called youth guarantee introduced at the beginning of 2013. This guarantees that all people under 25 and recent graduates aged under 30 are offered work, a traineeship, a place on a study course or rehabilitation within three months.

The Job Bank experiment, launched to increase employment among the long-term unemployed and persons with partial work ability, will be introduced across the country. Job Banks help people in a weak labour-market position to find employment. The employment allowance experiment also aims to boost employment. It involves giving the long-term unemployed in the participating municipalities an extra month's worth of labour-market support even if they have already found employment.

Employees with partial work ability should be encouraged to participate in the labour market by aligning their salaries and social security more effectively. Low-income households have benefited from increases in basic social security, minimum benefits and housing allowance.

Figure 12: Percentage of low-income population by type of family in 1995 and 2010



Improvements in well-being at work

Promoting functional capacity and work ability among the labour force and preventing work-related accidents and occupational diseases are among the most important aims of occupational safety and health. Occupational safety and health work supports physical and psychological well-being at work, how the labour force cope in their work, longer working careers and the underlying condition of autonomy at work. Occupational safety and health also strives to reduce psychosocial strain. The objective is to create the kind of management and safety culture that supports safety in the workplace. Ensuring well-being at work also results in healthier and more motivated employees. This improves productivity and competitiveness.

Responsibility for working conditions always rests with the employer. The occupational health and safety divisions of the Regional State Administrative Agencies are responsible for monitoring whether occupational safety and health legislation is observed in workplaces. Supervision by the authorities covers sectors and workplaces where supervision is believed to have the biggest impact.

The occupational safety and health administration supports employers in their efforts to ensure occupational safety and health and well-being at work. It evaluates the economic impacts of working conditions and financial incentives to improve working environments. A broad-based Well-being at Work Forum has been created to promote these issues.

The objective is to create healthy and safe working conditions to ensure well-being at work. The targets are to:

- reduce the number of occupational diseases by 10 per cent;
- reduce the frequency of workplace accidents by 25 per cent;
- reduce perceived physical strain by 20 per cent; and
- reduce perceived psychological strain by 20 per cent.

These targets are to be met by 2020.

Efforts are also made to improve access to occupational healthcare services and rehabilitation. Finland has had a number of extensive programmes to encourage longer working careers in the last ten years. In the future, the emphasis will be on increasing people's ability, willingness and opportunities to continue working. The work of the occupational safety and health authorities between 2012 and 2015 is especially aimed at lengthening working careers and combating the grey economy.

One goal is to facilitate employees' return to work after an illness and to make the evaluation of work ability more efficient. In the case of longer-term illnesses, occupational healthcare professionals have an obligation to evaluate the employee's work ability. Employers have a responsibility to evaluate the employee's opportunities for returning to work, in cooperation with the employee and occupational healthcare.

Occupational health and safety have improved both in the EU and outside the union with the help of European Health and Safety Campaigning. The theme for 2012 and 2013 is 'Working together for risk prevention'. Psychosocial risks will be the focus in 2014 and 2015.

The number of accidents in different industries relative to each other has remained almost unchanged. However, there are considerable differences in the number of accidents within industries. The construction industry has the highest incidence of work-related accidents. Despite this, many businesses have managed to eliminate all work-related accidents at individual building sites as part of safety competitions.

- The number of work-related accidents has remained relatively constant in the last ten years.
- According to provisional statistics, salaried employees were involved in just over 130,000 work-related accidents in 2011.
- Of these, 110,000 were accidents in the workplace and 22,000 accidents during work-related travel.
- The number of work-related accidents dropped considerably from 2008 to 2009. The reason is believed to be the economic recession.
- There were a total of 28 fatal workplace accidents in 2011.
- The number of fatal workplace accidents has dropped considerably in the light of long-term statistics.

Strenuous physical work is still common. Strenuous physical work has actually increased among women in recent years, both in the industrial sector and the catering and hospitality industry. The work-related risk that has increased the most, however, is hectic timescales.

Longer working careers

The number of people on disability pensions has remained almost unchanged in recent years. The number of people retiring on a disability pension each year has actually dropped in 2009 and 2010. The most common reasons for retiring on a disability pension are musculoskeletal diseases and mental health issues.

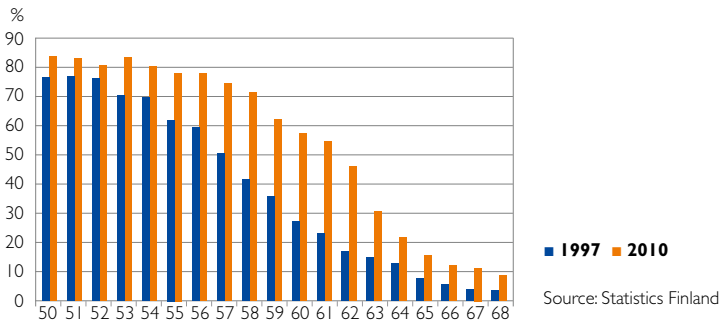
The number of people on old-age pensions has increased with ageing of the population. The number of people taking early retirement on whatever grounds is considerably lower than before. National pensions have become less important, because more and more retirees have had an opportunity to accumulate an earnings-related pension.

The income of those retiring on a national pension has been boosted by the introduction of a guaranteed minimum pension. The minimum pension increases the pension of low-income women in particular. The Finnish earnings-related pension scheme encourages people to continue working as they get older. The national pension age is 63, but anyone can continue working until the age of 68.

Ageing people are more and more active in the labour market, and people retire later and later. This trend is the result of Finland's pension reform as well as actions to improve working conditions, the labour market and people's work ability. The general attitude towards longer working careers, staying in work and older employees has become more positive. The average retirement age of people entitled to an earnings-related pension was 60.5 years in 2011. The average retirement age has risen by one and a half years since the pension reform.

New initiatives to promote longer working careers and well-being at work are in the pipeline. The option to retire early on an old-age pension has been removed to lengthen working careers. The age limit for part-time pensions and the so-called extra days in the earnings-related unemployment benefits scheme will be raised. Better coordination between salary and social security gives employees with partial work ability more opportunities to participate in the labour market. People's work ability is also promoted by timely rehabilitation. The Finnish government and social partners aim to implement the next earnings-related pension reform in 2017.

Figure 13: Employment among people aged between 50 and 64 in 1997 and 2011

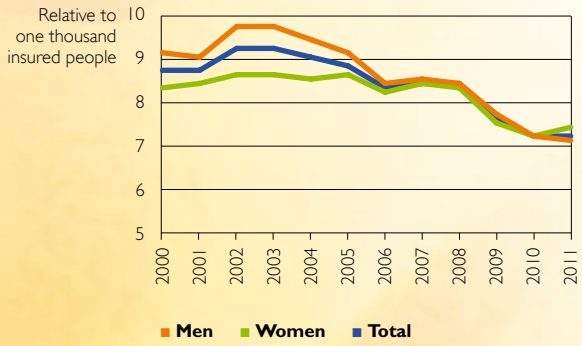


Source: Statistics Finland

The number of sick days has increased slightly among women and dropped among men. The most common reasons for sickness-related absences are musculoskeletal diseases and mental health issues. More than 4,000 people retire on a disability pension due to depression every year.

The partial sickness allowance that was introduced at the beginning of 2007 is aimed at preventing prolonged sickness-related absences and permanent incapacity for work. The partial sickness allowance supports rehabilitation and a return to work.

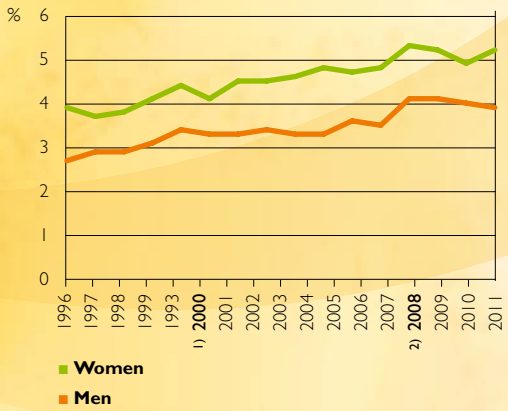
Figure 14: Retirement on a disability pension in the employee pension scheme between 2000 and 2011, age-standardised data



The data is age-standardised relative to the non-retired population insured by employee pension insurance in 2000

Source: Finnish Centre for Pensions

Figure 15: Days lost due to illness as a proportion of days at work between 1996 and 2011



1) Since 2000 data has been compiled by examining all weeks in a month, whereas before it was assessed on the basis of a single week. The new method takes better account of holidays and other absences at different time of the month.

2) The statistical specifications were changed in 2008; this explains about one third of the difference between 2008 and 2009

Source: Statistics Finland

The unemployment benefits system will be developed so as to make it more conducive to participation in active measures such as labour-market training, traineeships or supported employment. It is also hoped that the unemployment benefits system will help lengthen working careers from 2014. Failure to participate in the active measures specified in employment plans will result in 100 days less in unemployment benefits. Active measures will be promoted by shortening the period for which daily allowances are paid and by increasing the amount. The period for which unemployment benefits are available for unemployed jobseekers and young people with little employment history will be shortened to make them more likely to find employment faster.

Challenges posed by low incomes and long-term unemployment

The percentage of population on a low income increased in the 2000s, but the trend has petered out in recent years. The risk of poverty and exclusion from the labour market and education is often the highest among the same population groups. There are great regional differences in income levels and rates of employment.

The number of people receiving unemployment benefits and social assistance increased during the recession, but the trend has now taken a slight downward turn. Unemployment stood at approximately eight per cent at the end of 2012, and the situation is not expected to improve noticeably over the next few years if the problems with the economy continue.

What is especially worrying is the increase in the number of long-term unemployed and people relying on social assistance for extended periods of time, as well as increasingly widespread unemployment among young people. Working conditions have improved, and people retire later. The number of people on disability pensions is decreasing but still high. Depression in particular has become more common as a reason for incapacity for work.

The global economic crisis that began in 2008, financial problems in the public sector and rising unemployment have increased demand for social security. They have also made it more difficult to finance social security. GDP-equivalent social spending has increased in recent years. Despite this, Finland's social spending is close to the EU average.

Social spending amounted to approximately EUR 57 billion in 2011, of which the government budget covered just over a third. Social spending accounts for approximately 30 per cent of the gross domestic product. Social spending mostly comprises pensions, municipal social welfare and healthcare services, unemployment benefits and health insurance.

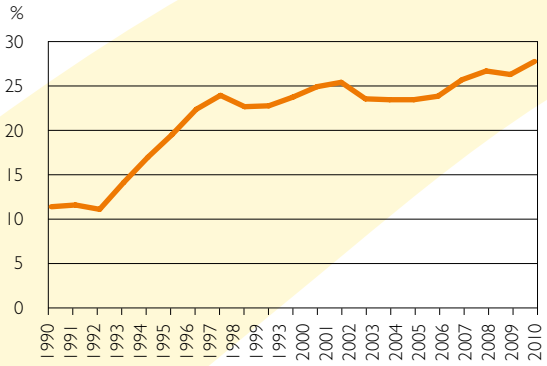
Efforts to reduce long-term homelessness

Although demand for substance-abuse services has increased, people are not seeking help for problems any more often than before. The number of doctor's appointments relating to mental health issues has increased slightly, but the number of patients in institutional treatment for mental health disorders has decreased. The percentage of people retiring on the grounds of mental health issues has increased alarmingly. This is especially the case among young people.

The number of people seeking social assistance is no longer increasing. The number of people relying on social assistance for extended periods of time, however, has increased. Long-term reliance on support is still a major problem. The number of people seeking unemployment benefits increases as the employment situation deteriorates. Housing costs are rising faster than incomes, which is particularly taxing on those in the lowest income bracket. High housing costs result in high-income and low-income population living in different areas.

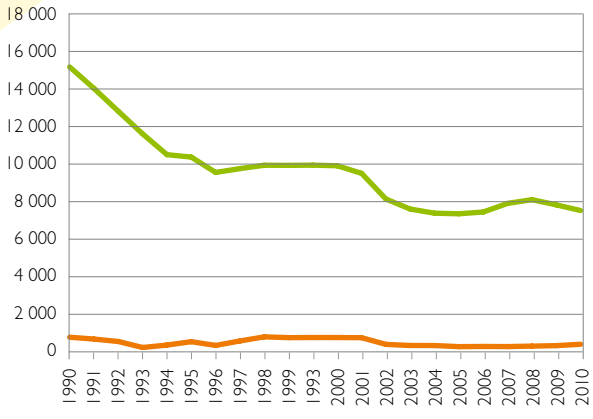
The social guarantee associated with social assistance is designed to guarantee access to municipal social services within a specific period of time.

Figure 16: Percentage of people on social assistance who received social assistance for between 10 and 12 months between 1990 and 2010



Source: National Institute for Health and Welfare

Figure 17: Number of homeless people between 1990 and 2011



Source: State Housing Fund

The number of homeless people has decreased. Those in the most vulnerable position have been given housing with the help of the Programme to Reduce Long-term Homelessness. The objective has been to halve homelessness by 2011 and to eliminate it altogether by the end of 2015. Homelessness in the Capital Region has been alleviated by means of a special Homelessness Programme. Efforts are made to combat social exclusion by early intervention in problems among children and young people, by supporting the integration of immigrants, by implementing alcohol and drug programmes and by preventing crime.

The third sector plays an important role in combating poverty and social exclusion. Non-governmental organisations have a responsibility in preventive action and as providers of services for special groups. In 2013, Finland's Slot Machine Association will provide funding of approximately EUR 300 million to the operations of non-governmental organisations.

The European Union's open method of coordination has increased national cooperation in reducing poverty and social exclusion. There are currently several initiatives funded by the EU in progress to support the employment of those in the weakest labour-market position. One of the objectives of the EU2020 strategy is to reduce poverty considerably.

Supporting the welfare of families

The daily lives of families are made easier by supporting parenthood and family unity. Costs resulting from children are offset by child benefit, for example, to prevent inequality between families. Children are given an opportunity to grow and develop in a safe environment. Support is also offered for reconciling work and family life.

Poverty among families has become more widespread. The low incomes of single parents are still a big problem. Nevertheless, when compared with most EU countries, relative poverty is low in Finland.

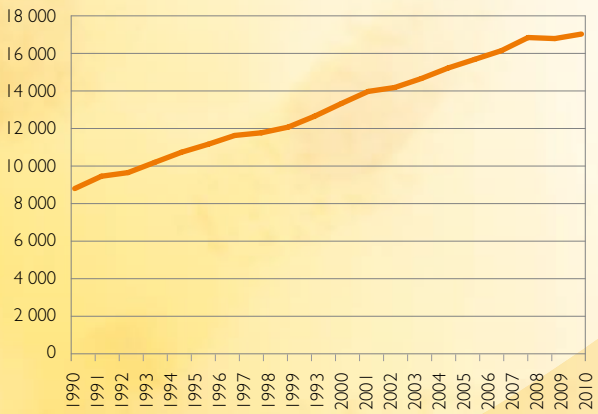
The Government Programme includes increases to several benefits for families. Single parents are now entitled to a higher rate of child benefit. The minimum rates of maternity, paternity and parental allowance as well as sickness allowance have been raised to the level of labour-market support and linked to the National Pensions Index. The Office of the Ombudsman for Children has established its position as a promoter of children's interests.

The most important benefits for families are child benefit and child day care. Child poverty is rare in Finland compared to other EU countries. The number of families living below the poverty line has nevertheless doubled since 1995. The situation is most serious among single-parent families and families with multiple children. More than a quarter of single-parent families live below the poverty line.

It is not easy to reconcile work and family life. Issues relating to this are being resolved. Costs incurred by employers due to family leave are shared by all employers so that it isn't just the employers of women that are affected.

Fathers have been taking more advantage of the family-leave system since the beginning of the 1990s. While only 42 per cent of fathers took paternity leave in 1990, this figure had risen to 72 per cent by 2010. The paternity leave available for fathers, which lasts approximately two months, gives parents a more even chance to spend time with small children. Paternity leave does not eat into the number of days that can be taken off as parental leave. The change means two weeks more of parental leave for either parent as well as more days of paternity leave for fathers.

Figure 18: Number of children placed outside the home between 1991 and 2011 (temporary placement due to child-protection concerns)



Source: National Institute for Health and Welfare

The number of children and parents requiring special support is still high. The number of children who have been taken into care and placed outside the home continues to increase. The reasons for taking children into care include parents' long-term unemployment, mental health issues and habitual alcohol or drug abuse by parents or children. On the other hand, the number of children and young people in non-institutional care has dropped.

The National Development Programme for Social Welfare and Health Care (Kaste programme) includes a reform of services for children, young people and families across the country. Five extensive development projects are receiving funding from the Finnish government, for example. The projects pool together services to support children's development and to prevent and resolve problems and adverse situations.

More and more children under school age attend day care. The proportion of children aged between three and five who are cared for outside the home has risen to 73%. The proportion among children aged one and two is 42%. Most children in this age group are cared for at home with the help of child home-care allowance.

Almost all children aged six attend preschool. The provision of before-school and after-school activities for schoolchildren has increased in recent years. Parents who work no more than 30 hours per week are entitled to a small compensation payment for reducing their working hours during their child's first and second year at school.

Stronger municipal service structures

One of the most important objectives of Prime Minister Jyrki Katainen's cabinet is a local government reform to increase the vitality of municipalities. Another important reform involves social welfare and healthcare service structures. The reform is aimed at guaranteeing access to timely, high-quality services regardless of where someone lives. The objective of the service structure reform is to create a strong municipal service system. This requires higher populations than what the municipalities have at the moment. It would allow the local or regional authorities responsible for the provision of social welfare and healthcare services to meet their obligations in an economical way and to provide services with better equality than before.

As the population ages, municipal finances need to be in order. Local authorities also need to be able to take care of the basic structures of society, and they need to have enough competent personnel.

The National Development Programme for Social Welfare and Health Care (2012–2015) involves revising legislation on the access to treatment. The Ministry of Social Affairs and Health, the National Institute for Health and Welfare and the Association of Finnish Local and Regional Authorities are pooling their resources to evaluate how well the access-to-treatment provisions included in the Health Care Act are being implemented in practice and what factors contribute to queues in healthcare.

Special legislation governing social services is also being revised. Work to reform social welfare and health-care structures continues.

National development programme to reform services

The National Development Programme for Social Welfare and Health Care is designed for creating, evaluating, sharing and entrenching new, good practices. It is a programme that pools together the development of social welfare and healthcare services and incorporates other important social welfare and healthcare programmes. The objective is to reduce welfare and health inequalities and to rebuild social welfare and healthcare structures on clients' terms. Instead of dealing with problems, the goal is to prevent them. A secondary objective is to promote physical, psychological and social well-being.

The programme includes six sub-programmes which:

- improve opportunities for social inclusion, welfare and health in high-risk groups;
- improve services for children, young people and families;
- reform the structure and scope of services for older people;
- strengthen service structures and basic services;
- increase the information system know-how of clients and professionals; and
- support, by means of management, the reform of service structures and well-being at work.

The implementation of the National Development Programme for Social Welfare and Health Care is guided by a national action plan for 2012–2015. The programme has links to both the Government Programme and the ministry's strategy.

The primary objectives are to increase the participation of residents, to improve the population's welfare and health, to prevent social exclusion, and to reduce welfare and health inequalities. Secondary aims are to improve the quality of services and to increase their availability and impact. Reducing regional inequalities is an important goal. Special focus is given to services for older people and for children and families.

Guaranteed access to treatment – maximum queuing times for non-urgent cases

Provisions on the scope of healthcare services are included in the Health Care Act. The act lays down how quickly patients must be seen. The National Institute for Health and Welfare regularly monitors access to primary healthcare and specialised medical care in non-urgent cases. The time it takes to get a doctor's appointment has varied considerably from one health centre to another.

The situation has improved in dental care.

- The number of patients who had waited for more than three months to get treatment was approximately 30,000 in March 2012. This figure is approximately eight per cent lower than in October 2011.
- The number of patients who had waited for more than six months was 12,200. This figure is 12 per cent lower than in October 2011.

In specialised medical care, the situation has deteriorated.

- The number of patients who had waited for more than six months to get treatment in hospital districts increased by more than 700 in the summer of 2012.
- At the end of August, more than 73,000 patients were queuing for treatment in hospital districts and specialised medical care provided through primary healthcare.
- Approximately 1,800 of these patients had been queuing for treatment for more than six months.

The Ministry of Social Affairs and Health is due to launch a survey into how well the maximum queuing times for treatment are actually being implemented in practice. The programme includes actions to ensure the availability of basic services.

The Health Care Act gives citizens a stronger voice as users of healthcare services. It also reinforces the role of the individual in producing a personal care and treatment plan. Patients are expected to define the goals that will allow them to cope themselves, which are then supported by services planned by professionals and agreed with the patient in question.

Maximum queuing times for treatment

- Patients in need of urgent care must be seen immediately.
- Patients must be able to reach health centres by telephone without delay during office hours, i.e. the health centre's official opening hours.
- Health centres must begin an assessment of a patient's need for treatment within three days of the patient contacting the health centre.
- The assessment can be carried out over the telephone. Healthcare professionals besides the doctors can carry out the assessment.
- A doctor must assess a patient's need for treatment within three weeks when a patient is referred to a hospital.
- If the doctor concludes that the patient requires hospital treatment, the treatment must begin within a maximum of six months.

Until the end of 2013, citizens can choose which health centre in their home municipality or local government joint services area to go to for primary healthcare services. Patients can change from one health centre to another by giving written notice; patients can only change health centres once a year at most. Moreover, patients can only be registered with one health centre at a time. Patients residing outside their home municipality for extended periods of time (e.g. during the summer) can receive treatment, according to their personal care and treatment plans, in a health centre in their temporary home municipality.

Individuals requiring specialised medical care services can choose a treatment provider within their local catchment area. In some circumstances, treatment can also be given in another catchment area. The treatment provider is chosen together with the referring doctor. Patients also have the right to choose their own doctor or other healthcare professional.

Patients' rights to choose where they receive treatment will increase as of 2014. This is when the EU Directive on the application of patients' rights in cross-border healthcare enters into force, allowing patients to seek treatment across territorial boundaries. The directive will give patients the right to choose their health centre or specialised medical care provider from all of Finland's public health centres and hospitals.

The Ministry of Social Affairs and Health has defined the most important targets for Finland's medicines policy for a decade. According to the targets, medicines must be available everywhere in Finland, and pharmaceutical safety must be kept at a high level.

Pharmaceutical research needs to be subsidised in order to allow for pharmaceutical development in the future. Efforts are made to promote rational prescription and the correct use of medicines. The reference price system has worked well in curbing the rising costs of medicines. The system of reimbursing the cost of medicines will undergo further development, taking account of the principles outlined in Finland's Medicines Policy 2020.

Efficient social services

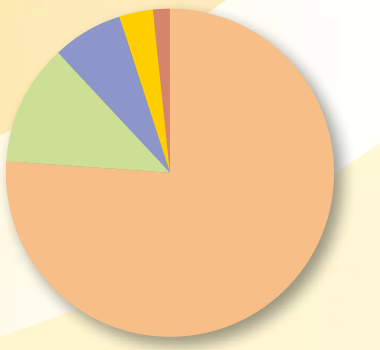
The entire social welfare sector is undergoing reform. More emphasis is given to prevention. The objective is to place clients at the core of the services and to allow them to take a more active role in planning services. The development of social services has also been incorporated into the National Development Programme for Social Welfare and Health Care.

Older people and people with disabilities are guaranteed an opportunity to live in their own homes for as long as possible. When this is no longer possible, they are provided with housing that resembles living in their own home. More and more people are offered a place in supported housing or an assisted-living residence. Older people and people with disabilities living in their own homes are supported by means of home help and/or home nursing services as well as informal caregivers. These principles are included in the new Act on Care Services for Older People, which enters into force in the spring of 2013. A new national framework for high-quality services for older people will also be adopted at this time.

Revisions to the Services and Assistance for the Disabled Act of 2009 are aimed at promoting the equal opportunities of people with severe disabilities as well as reinforcing fundamental and human rights. This also increases the independence of people with severe disabilities, their autonomy and their opportunities to participate in society. A housing programme for people with intellectual disabilities has been launched to give them more opportunities to live independently, which reinforces their right to social inclusion and equal opportunities. The objective is to reduce institutional care by introducing more personalised and more social forms of community support and services.

Municipal social welfare and healthcare spending continues to increase year after year. At the moment, spending stands at more than 50 per cent on average. Local authorities receive central government transfers for the provision of social welfare and healthcare services, which account for just under a third of municipal spending. The level of transfers has increased considerably in recent years. The number of people on social assistance began to increase in 2009. Just under seven per cent of Finns receive social assistance over the course of a normal year.

Figure 19: Housing and services for people aged over 75 in the 2000s



Source: National Institute for Health and Welfare

THE ROAD **AHEAD**

Social welfare and healthcare policy challenges

- Globalisation
- Ageing of the population
- Economic development
- Regional development
- Changes in living environments
- Increasing social diversity
- Employment and labour-market development
- Advances in technology and interaction

Priorities

- Improving people's functional capacity and work ability
- Reducing welfare and health inequalities
- Combating obesity
- Reducing the harm from substance abuse
- Lengthening working careers
- Reducing sickness-related absences
- Increasing well-being at work
- Preventing depression
- Making social security more incentive-based
- Reducing long-term unemployment
- Reducing poverty among families
- Securing access to substance-abuse and drug rehabilitation services
- Implementing the reform of social welfare and healthcare service structures
- Ensuring the availability of social welfare and healthcare personnel
- Overhauling social welfare legislation
- Reconciling work and family life
- Securing families' access to special services
- Ensuring a safe environment for children to grow up in
- Implementing the Act on Equality between Women and Men
- Reducing pay inequalities between women and men
- Reducing violence against women

EXPERTISE WITHIN THE ADMINISTRATIVE BRANCH OF THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH

There are a number of independent government agencies and public bodies carrying out research and development to support the work of the Ministry of Social Affairs and Health. They produce information to support legislative development, social and health policy development and decision-making. They also help the ministry to implement reforms. Some of the government agencies act as licence and supervisory authorities. More than 4,000 people are employed in government agencies and public bodies within the ministry's administrative branch.

The National Institute for Health and Welfare is a research and development organisation responsible for promoting the welfare and health of the population, preventing illnesses and social problems and developing social welfare and healthcare services. The National Institute for Health and Welfare acts as the statistical authority for health and welfare, and as the administrator of health and welfare information and the use of this.

www.thl.fi

The Finnish National Supervisory Authority for Welfare and Health improves the management of health risks in the environment, legal protection and the quality of social welfare and healthcare services by means of guidance and supervision.

www.valvira.fi

The Finnish Medicines Agency (Fimea) is responsible for pharmaceutical licensing and supervision, pharmaceutical research and development, and for producing and distributing information about medicines to improve the effectiveness of pharmaceutical services and medicinal treatments.

www.fimea.fi

The Social Security Appeal Board is an appeals tribunal equivalent to a specialist social insurance court in the administrative branch of the Ministry of Social Affairs and Health.

The Unemployment Appeal Board is a social insurance appeals tribunal for matters involving unemployment benefits.

www.stm.fi > Contact > Advisory boards and committees

The Radiation and Nuclear Safety Authority supervises nuclear plants, nuclear material and nuclear waste as well as the use of radiation and radioactive substances in healthcare, industry, research and teaching.

www.stuk.fi

The Finnish Institute of Occupational Health is a multidisciplinary research and consultancy organisation that promotes functional capacity and work ability, overall health and quality of life among Finland's working-age population.

www.ttl.fi

Finland's Slot Machine Association operates gaming machines to collect funds for supporting Finnish non-governmental social welfare and healthcare organisations.

www.ray.fi

Occupational safety and health divisions of Regional State Administrative Agencies are responsible for the supervision of occupational safety and health. They monitor compliance with occupational safety and health legislation in workplaces and give advice and guidance on good occupational safety and health practice. The objective of supervision and guidance from the authorities is to help workplaces become more self-reliant in evaluating working conditions and in taking action to improve them.

www.tyosuojelu.fi

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